**An independent watchdog of the Global Fund, and publisher of *Global Fund Observer***

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# Aidspan White Paper

# Scaling Up to Meet the Need: Overcoming barriers to the development of bold Global Fund-financed programs

**21 April 2008**

by

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Funding provided entirely by Dr. Albert and Mrs. Monique Heijn

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# Preface

This white paper is one of over a dozen free Aidspan publications written for those applying for, implementing, or supporting grants from the *Global Fund to Fight AIDS, Tuberculosis and Malaria* (the Global Fund). The following is a partial list of Aidspan's publications.

- ***Global Fund Observer:*** A free email newsletter providing news, analysis and commentary to over 7,000 subscribers in 170 countries. (87 issues over the past five years; currently in English only.)
- ***Aidspan White Paper: Providing Improved Technical Support to Enhance the Effectiveness of Global Fund Grants*** (March 2008; available in English only)
- ***The Aidspan Guide to Round 8 Applications to the Global Fund – Volume 1: Getting a Head Start*** (January 2008; available in English, French and Spanish)
- ***The Aidspan Guide to Round 8 Applications to the Global Fund – Volume 2: The Applications Process and the Proposal Form*** (March 2008; available in English, French and Spanish)
- ***Aidspan Documents for In-Country Submissions*** (December 2007; available in English, French, Spanish and Russian)
- ***The Aidspan Guide to Building and Running an Effective Country Coordinating Mechanism (CCM)*** (Second edition September 2007; available in English, French and Spanish)
- ***The Aidspan Guide to Understanding Global Fund Processes for Grant Implementation – Volume 1: From Grant Approval to Signing the Grant Agreement*** (December 2005; originally titled "*The Aidspan Guide to Effective Implementation of Global Fund Grants"*. Available in English only.)
- ***The Aidspan Guide to Understanding Global Fund Processes for Grant Implementation – Volume 2: From First Disbursement to Phase 2 Renewal*** (November 2007; available in English, French and Spanish)
- ***The Aidspan Guide to Developing Global Fund Proposals to Benefit Children Affected by HIV/AIDS*** (May 2006; available in English only)
- ***The Aidspan Guide to Obtaining Global Fund-Related Technical Assistance*** (January 2004; available in English only)

### *Downloads*

To download a copy of any of these publications, go to www.aidspan.org. If you do not have access to the web but you do have access to email, send a request to guides@aidspan.org specifying which publications you would like to receive as attachments to an email. Aidspan does not produce or distribute printed copies of these publications.

### *Aidspan*

Aidspan is a non-governmental organization originally based in New York, USA, but since mid-2007 based in Nairobi, Kenya. Its mission is to reinforce the effectiveness of the *Global Fund to Fight AIDS, Tuberculosis and Malaria*. Aidspan performs this mission by serving as an independent watchdog of the Fund, and by providing services that can benefit all countries wishing to obtain and make effective use of Global Fund financing.

Aidspan also publishes the *Global Fund Observer (GFO)* newsletter, an independent email-based source of news, analysis and commentary about the Global Fund. To receive GFO at

no charge, send an email to receive-gfo-newsletter@aidspan.org. The subject line and text area can be left blank.

Aidspan finances its work primarily through grants from foundations. Aidspan does not accept Global Fund money, perform paid consulting work, or charge for any of its products.

Aidspan and the Global Fund maintain a positive working relationship, but have no formal connection. *The board and staff of the Global Fund have no influence on, and bear no responsibility for, the content of this white paper or of any other Aidspan publication.*

### *Acknowledgements, Permissions, Feedback*

Aidspan thanks its funders for the support they have provided for 2003-2008 operations – The Monument Trust, Dr. Albert and Mrs. Monique Heijn, the Open Society Institute, Irish Aid, the Foundation for the Treatment of Children with AIDS, Merck & Co., UNAIDS, Anglo American, the Glaser Progress Foundation, the John M. Lloyd Foundation, the MAC AIDS Fund, GTZ, and two private donors. See note under "Funding" in Chapter 1 for details regarding the funding of the project described in this white paper.

The author thanks Aidspan's Angela Kageni for the interviews she conducted and the memos she wrote in Uganda, Rwanda and Nigeria during preparatory work for this white paper. He thanks those whom Angela interviewed, and those he interviewed himself in Burundi, DR Congo, Kenya and Zambia, for their time and openness. He thanks Matthew Greenall for the appendix that he researched and wrote. And finally, he thanks all the participants who attended the second Global Fund Round Table (RT2); their input at that meeting provided the intellectual underpinning for most of the recommendations contained in Chapters 4 and 5.



Readers are invited to email Bernard Rivers (rivers@aidspan.org), Executive Director of Aidspan, with questions, comments, or suggestions for improvements to this white paper.

# List of abbreviations and acronyms

The following is a list of the main abbreviations and acronyms used in this white paper:

| | |
|---|---|
| CCM | Country Coordinating Mechanism |
| GF | The Global Fund to Fights AIDS, Tuberculosis and Malaria |
| GFO | Global Fund Observer |
| LFA | Local Fund Agent |
| NGO | Non-governmental organisation |
| PR | Principal Recipient |
| RCC | Rolling Continuation Channel |
| SR | Sub-Recipient |
| TB | Tuberculosis |
| TRP | Technical Review Panel |
| TS | Technical Support (also known as Technical Assistance, TA) |
| UNAIDS | United Nations Joint Programme on HIV and AIDS |
| WHO | World Health Organization |

# Executive Summary

The Global Fund is a little over six years old. Last year it approved grants worth nearly $3 billion, double what it approved in its first year. And the GF Board agreed last year that by 2010 it expects to approve grants worth $6 billion or more annually.

If the Fund is to achieve continued rapid growth, it has to examine closely, and address, some significant growing pains that are becoming increasingly apparent. Some of these growing pains exist within developing countries; others exist within the Fund itself.

Accordingly, this white paper tackles three linked questions:

(a) What problems *at the country level* are preventing adequate scale-up to meet the need?

(b) What problems *at the Global Fund level* are preventing adequate scale-up by the countries?

(c) What should be done about these problems?

These issues were discussed at the second "Global Fund Round Table" (RT2), organized in South Africa in early April 2008 by Aidspan. The meeting consisted of a private "conversation" between eighteen people representing government, civil society, the Global Fund and others. Two-thirds of the participants are based in Africa. Participants agreed that Aidspan would produce this white paper, based in large part on problems and recommendations that were discussed at the Round Table. Aidspan alone is responsible for the contents of this white paper, and no specific participant at the Round Table can be assumed to agree with any specific opinion or recommendation that the white paper contains.

Most of the problems related to scaling up that are described in this paper were identified during interviews conducted in seven African countries during the preparations for RT2.

Problems *at the country level* that are preventing adequate scale-up to meet the need include the following:

- Many implementing countries have weak health systems, limited capacity, and insufficient health workers.
    - Sample quote: "If we train people in one province, next time we go there, we find they are gone…"
- Some countries have an unclear national strategy regarding the three diseases, or poor national planning.
    - Sample quote: "Two weeks before submission of our Round 7 malaria proposal, there was a major shift in our country's malaria strategy." [The proposal was not approved. The country has one of the largest malaria burdens in Africa.]
- The CCM is often weak, or people are not clear about its role, or there are tensions within it. It often does poor planning regarding preparation of its proposals to the GF.
    - Sample quote: "The CCM lacks authority. People can't agree whether it should act like a board, a committee, or an institution…"

Problems *at the Global Fund level* that are preventing adequate scale up to meet the need include the following:

- The GF proposal development process is long and complex. It is a deterrent.
    - Sample quote: "Even if the proposal-writing team has seminars and workshops to develop the ideas for a proposal, it won't be acceptable as a proposal unless very high-level experts write it; so it is the proposal of the experts, not of the country."
- There is no TRP feedback until after a decision is made, so iterative improvement of the proposal is not possible.
    - Sample quote: "Because the TRP process can lead to 'sudden death', applicants are forced to be risk averse. Consequently, bold and ambitious requests are less likely."
- Some of the GF's rules for grant implementers are too burdensome, or they are enforced in too rigid a manner. The transaction costs of dealing with the GF are too high.
    - Sample quote: "We [a PR] have five ongoing GF grants. With these grants, in the course of nine months, we have had to deal with Phase 2 renewal for two grants, RCC for three grants, quarterly reporting, Round 7 proposal development, ongoing LFA issues, CCM meetings, GF workshops. We have no time to think; no time to implement; we are just dealing with the GF and GF issues."

This white paper contains six major recommendations to the Global Fund, and a number of more modest recommendations. The major recommendations are as follows:

- Significantly enhance GF support for Health Systems Strengthening (HSS).
- Dramatically reduce the administrative burden associated with implementing multiple GF grants, and simplify the processes for extending or expanding well-performing grants, by moving towards one “single-stream grant” for each country/disease/PR combination.
- Improve the applications process by introducing a quarterly cycle for accepting proposals, and by extending the time allowed for proposal development.
- Encourage the establishment of a *Pre-Proposal Mentoring Panel.*
- Establish a two-step proposal-approval process.
- Participate in, convene, or lead a global discussion on what institutional architecture is most suited to achieving the increases in funding and programs that are needed to achieve the health-related Millennium Development Goals, and in particular whether there should be a "Global Health Fund".

Many of the discussions before and during RT2 focussed on African countries. However, we believe that the problems discussed in this white paper are also found in many other developing countries, and that the recommendations will be helpful in those contexts also.

The recommendations in this white paper are offered to stimulate thought among a wide range of Global Fund stakeholders, and possible action by these stakeholders, particularly those represented on the GF board. In some cases, it would be possible to take action at the forthcoming board meeting (27-29 April 2008), thereby benefiting those who are about to submit Round 8 applications. In other cases, it would be possible to take action in time to impact 2009 activities.

# Chapter 1: Introduction

## Global Fund Round Tables

From time to time, Aidspan organizes a "Global Fund Round Table" to discuss a single big-picture issue regarding which innovative and collaborative action is needed not just by the *Global Fund to Fight AIDS, Tuberculosis and Malaria* (Global Fund, or GF), but also by other players. Each meeting consists, in effect, of a private conversation between about twenty leaders representing government, civil society and multilateral agencies. Participants discuss the problems and possibilities of the chosen topic, sharing opinions on creative ways forward. Participants attend in their personal rather than official capacities, and agree not to reveal "who said what". For each Round Table it is possible – though obviously not certain – that the discussions will have a subsequent impact on the policies and procedures of the Global Fund and others.

The first Round Table, RT1, in January 2007, discussed how to ensure that implementers of programs funded by the GF have access to adequate and appropriate technical support. Details are available in the Aidspan white paper "Providing Improved Technical Support to Enhance the Effectiveness of Global Fund Grants", accessible at www.aidspan.org.

The second Round Table, RT2, in April 2008, discussed what the GF and others can do to enable countries funded by the GF to significantly increase the scale of their operations. (See further description below.)

## Universal access

In 2005, G8 leaders pledged to come "as close as possible to universal access to treatment [for HIV/AIDS] for all those who need it by 2010." Today, only about one in four people in developing countries who need HIV treatment have access to it, and only one in five people globally have access to appropriate HIV prevention. In partial response, the GF Board agreed in April 2007 that it expects the Fund to at least triple in size by 2010, and it agreed not just to provide financial support to countries that develop good program-based proposals but also to fill funding gaps in strong independently-reviewed national strategies.

However, although the ***need*** for treatment and support services for people impacted by the three pandemics worldwide is enormous, the ***demand***, as expressed in technically sound proposals to the Global Fund, is at present significantly less.

As a senior official in one developing country put it, the situation in each country with regard to scaling up to meet the need is equivalent to when a large group of people must use a bus to undertake a crucial journey. If the bus is too small, or it goes too slowly, or it takes a wrong turn, or its mechanical problems are not fixed, or it is badly driven, it won't reach its destination in time. Simply pouring in more fuel (money) won't resolve these problems. Government and other players in the countries involved must deal with ***all*** the issues if the journey is to succeed.

## RT2 topic – Scaling up to meet the need

Accordingly, RT2, the second Round Table, focused on what the Global Fund and others can do to help developing countries to "scale up to meet the need" by developing and effectively implementing bigger and better programs and national strategies that will get them closer to universal access by 2010. The meeting took place on 2-4 April 2008 near Pretoria, South Africa.

## RT2 participants

RT2 was attended by the following:

| Participant | Role | Country in which based |
|---|---|---|
| Peter van Rooijen *(Moderator)* | Former board member, Global Fund, representing Developed Country NGOs | Netherlands |
| Dr. Christoph Benn | Director of External Relations, Global Fund Secretariat | Switzerland |
| Dr. Brian Brink | Alternate Private Sector Global Fund board member; and Group Medical Consultant, Anglo American. | South Africa |
| Dr. Jonathan Broomberg | Former Global Fund TRP Chair | South Africa |
| Ruwan de Mel | General Manager, Portfolio Services and Projects Group, Global Fund. | Switzerland |
| Dr. Peter Figueroa | CCM Chair and Director of National HIV Program, Jamaica | Jamaica |
| Dr. Akudo Anyanwu Ikemba | CEO, Friends of the Global Fund Africa | Nigeria |
| Angela Kageni | Programme Coordinator, Aidspan | Kenya |
| Elizabeth Mataka | Vice-Chair, Global Fund board; and UN Secretary-General's Special Envoy for AIDS in Africa | Zambia |
| Bernard Mendy | Gambia CCM Chair | Gambia |
| Sisonke Msimang | Open Society Initiative for Southern Africa | South Africa |
| Dr. Gorik Ooms | Executive Director, MSF (Médecins Sans Frontières), Belgium | Belgium |
| Bernard Rivers | Executive Director, Aidspan | Kenya |
| Tal Sagorsky | Liaison to the Vice-Chair of the Global Fund Board | Zambia |
| Dr. Elhadj Amadou (As) Sy | Director, Partnerships and External Relations, UNAIDS; former Global Fund Africa Director | Switzerland |
| Dr. Esther Tallah | Manager, Cameroon Coalition for the fight Against Malaria | Cameroon |
| Dr. Michael Tawanda | Regional Advisor, Swedish/Norwegian Regional HIV/AIDS Team for Africa, Lusaka | Zambia |
| Enid Wamani | Vice-Chair, Uganda CCM; and Coordinator, Malaria and Childhood Illness NGO Secretariat, Uganda | Uganda |

## Steering Committee

In organizing the Round Tables, Aidspan was guided by a Steering Committee that is entirely independent of the Global Fund and of the other major agencies. The members are:

- Dr. Alex Coutinho, Uganda (Former CEO, The AIDS Support Organization, Uganda, Africa's largest NGO dealing with AIDS. Former Vice-Chair, GF Technical Review Panel.)
- Mabel van Oranje, Netherlands (Global Fund board delegation member representing the Foundations sector. Director EU Affairs, Open Society Institute.)
- Dr. Steve Radelet, USA (Senior Fellow, Center for Global Development. Former Deputy Assistant Secretary of the U.S. Treasury for Africa, the Middle East, and Asia.)
- Peter van Rooijen, Netherlands (Former Global Fund board member representing Developed Country NGOs. Former Chair of the two largest AIDS NGOs in the Netherlands.)

- Dr. Suwit Wibulpolprasert, Thailand (Senior Advisor on Disease Control, Ministry of Public Health, Thailand. Former Vice-Chair, Global Fund board; member and former acting chair of the Program Coordinating Board of UNAIDS.)
- Dr. Ngaire Woods, New Zealand (Director, Global Economic Governance Programme, Oxford University.)

## Funding for the Round Tables

The entire cost of preparing and hosting RT1 and RT2 was generously underwritten by Dr. Albert and Mrs. Monique Heijn. Dr. Heijn is the former president and CEO of the Albert Heijn supermarket chain and of Royal Ahold NV. Dr. and Mrs. Heijn have long been interested in problems of HIV/AIDS in developing countries and have shown leadership in involving the business sector in the fight against HIV/AIDS. They hosted RT1 at their country estate, Pudleston Court, near Hereford, England.

## Working methods for RT2

In preparation for RT2, Aidspan's Bernard Rivers and Angela Kageni conducted 54 interviews with individuals or groups in Burundi, DR Congo, Kenya, Nigeria, Rwanda, Uganda and Zambia. They met with people ranging from Ministers of Health to AIDS activists, asking them, on a confidential basis, for their views on the following three questions.

(a) What factors *at the country level* are preventing adequate scale-up to meet the need?

(b) What factors *at the Global Fund level* are preventing adequate scale-up by the countries?

(c) What could/should be done about these factors?

People were asked to speak candidly and privately, so that Aidspan could create a document containing various “perspectives from implementing countries” for input to RT2.

In addition, Aidspan wrote to people who had been invited to be RT2 participants, giving them the chance to provide their own views via email, on the same confidential basis.

At RT2, participants discussed the input documentation, together with their own experiences and insights; they also suggested recommendations, and commented on those made by each other.

## The role of this white paper

Participants at RT2 accepted Aidspan's proposal that it would produce a white paper based on the input documentation and the discussions that took place at the meeting. Participants agreed that they would not, as such, "vote" on the recommendations, and that Aidspan was free to refine some of the concepts subsequent to the meeting. This document is that white paper.

Aidspan alone is responsible for the contents of this white paper, and no specific participant at the Round Table can be assumed to agree with any specific opinion or recommendation that the white paper contains.

This white paper is written for readers who are involved in applying for, implementing, overseeing or supporting the implementation of grants from the Global Fund, or who are

Global Fund board or staff members. Accordingly, it assumes a strong familiarity with the Global Fund and its processes.

Most of the problems related to scaling up that are described in this paper were identified during the research prior to RT2; a few additional ones were identified during RT2 itself. Most of the quotes were garnered during the prior research; again, a few are from the RT2 meeting itself. The list of problems is not meant to be exhaustive; there are certainly others not identified here.

The recommendations contained in this paper represent a collection of possible actions that Aidspan identified before and during the RT2 discussions. They are offered here to stimulate thought and action by and among a wide range of Global Fund stakeholders.

Insofar as Aidspan receives extensive feedback to this white paper that adds to or improves upon the background, analysis, opinions and recommendations that it contains, it will produce a second edition of this white paper later in 2008.

## Contents of this paper

Chapters 1 and 2 identify some of the factors preventing adequate scale-up to meet the need: factors *at the country level* feature in Chapter 1, and factors *at the Global Fund level* feature in Chapter 2. In Chapters 4 and 5 we provide some recommendations. The Appendix contains an analysis of existing institutional policies, practices and plans related to scaling up.

# Chapter 2: Factors *at the country level* that are preventing adequate scale-up to meet the need

**Note re Chapters 2 and 3:** The problems in these two chapters were identified during the pre-RT2 interviews that Aidspan conducted in person in Burundi, DR Congo, Kenya, Nigeria, Rwanda, Uganda and Zambia, and by email with RT2 invitees. In these interviews, people were asked "What factors at the country level [Chapter 2] and the Global Fund level [Chapter 3] are preventing adequate scale up to meet the need?"

The wording of the question meant that interviewees did not focus on things that are going smoothly, or on why they support the GF as an institution. Some interviewees had a few frustrations; some had many. But not one person expressed regret that their country had applied for, or received, GF grants. The quotes will be misleading if this context is not recognized.

As was promised to interviewees, countries, institutions and speakers are not identified here, and will not be identified elsewhere. The quotes capture the precise sense and tone of what specific individuals said, but are sometimes reduced in length from the actual wording used. The words “we”, “our country”, etc., refer to people in the speaker’s country. Obviously, not all people interviewed will agree with all points captured here.

## Problem 1: Many implementing countries have weak health systems, limited capacity, and insufficient health workers

*Quotes:*

(a) "If we train people in one province, next time we go there, we find they are gone. Health workers are paid very little, and they will always move if they can find a better paid job. Some doctors just move to [the neighbouring country], where they are paid much more for the same work."

(b) "Our country can't double the scale of HIV activities without investing in health systems capacity. We have only one medical school. And we can't train more nurses without spending on housing, tutors, etc."

(c) "You can't run a health system without an information system. That's like running a bank without computers."

(d) Even when adequately funded, some health institutions are run so badly that no health worker enjoys working there.

(e) "The GF is at a philosophical cross-roads. Throwing more money at the diseases and not at the systems is not going to be productive."

(f) "Having a weak health system not only makes it hard to scale up the response; it also means that the health system starts to get weaker, through burn-out of staff and through other systematic breakdowns resulting from excessive stresses upon the system."

### Problem 2: Some countries have an unclear national strategy regarding the three diseases, or poor national planning

*Quotes:*

(a) "Two weeks before submission of our Round 7 malaria proposal, there was a major shift in our country's malaria strategy." [The proposal was not approved. The country has one of the largest malaria burdens in Africa.]

(b) "The current national strategic plan is already outdated, and we haven't agreed when there will be a new one."

(c) "Less than ten percent of people with HIV in our country who need ARVs are getting them. And those that are getting them will lose them in 2009, when the current grant ends, if we don't get a Round 8 grant approved. But the government sleeps, and therefore the CCM sleeps; they don't treat it as urgent."

(d) "The debates in our country about the GF are focused primarily on HIV. But the reality here is that HIV is not the only burden; there are also huge malaria and TB burdens. But civil society is fixated on HIV."

(e) "If ministries of health don't receive significant funding to fight the top ten causes of mortality and morbidity (including the childhood diseases like hookworm and diarrhoea), their ministers will be hesitant to scale up on AIDS."

(f) "Those who support the 'horizontal' approach believe that too much money is going to AIDS and that therefore the overall health response is unbalanced and ineffective. Those that support the 'vertical' approach believe that there is no reason to hold back on the AIDS response while waiting for other elements of essential quality health services and health action to be developed."

(g) "Ministers change constantly."

(h) "Countries that are trying to limit external funding have created artificial caps on what they accept."

### Problem 3: The CCM is often weak, or people are not clear about its role, or there are tensions within it. It often does poor planning regarding preparation of its proposals to the GF.

*Quotes:*

(a) "The responsibility of the CCM to play an oversight role over grants has not been clearly defined by the GF. With no clear definition, and with PRs and SRs often being CCM members, the oversight role is frequently ignored."

(b) "Our CCM Chair is the Permanent Secretary of the Ministry of Health. The CCM Secretary is a civil servant in the MOH. The vice-chairs are not very involved. Thus, the CCM is insufficiently independent of the MOH. We need a stronger and more independent CCM Secretariat, with a recruited Executive Secretary."

(c) "There is a battle of trust, and paranoia is rampant between government and civil society."

(d) "The civil society representatives on the CCM keep changing, with no handover, and they're often poorly informed."

(e) "CCMs receive insufficient funding to play an effective and independent role."

(f) "The CCM lacks authority. People can't agree whether it should act like a board, a committee, or an institution; therefore they can't agree if it should have its own budget, its own office, etc."

(g) "The CCM in [the neighbouring country] spends much less time than ours does on politics, and much more time on what it needs to do to get implementation to work."

(h) "Even though people now know long before the GF's Call for Proposals when that Call will be issued, CCMs often are only galvanised into action after the date of the Call."

(i) "Developing a proposal, including ensuring input from multiple stakeholders, requires a classic 'project management' approach. But this is rarely done."

(j) "CCMs still sometimes ignore TRP feedback from prior unsuccessful proposals."

### Problem 4: NGOs and private sector companies are often ignored as potential PRs/SRs

*Quotes:*

(a) "NGOs and private sector companies should not be seen by national governments as competitors; they should be seen as potential partners and as potential providers of additional absorptive capacity."

(b) "Forty percent of health care delivery in our country comes from non-state actors. Also, with non-state actors, a higher percentage of the money given to them is actually used as intended, the money moves faster, and there is less bureaucracy. So any significant scale-up plan has to focus on more than the public sector."

(c) "Without an effective engagement of the private sector as implementing partners, the Fund may not succeed in achieving a serious scaling-up of effective demand in developing countries."

(d) *An alternative perspective:* "The GF and other such initiatives insist a lot on using NGOs. Some NGOs are good and have a track record. But most just want to use the resources to cater for themselves. Governments complain about this, but the complaints are not heard. If the government is able to influence which NGOs get used, it would be better. Also, the emphasis on using NGOs should not be a condition for a grant to be approved."

### Problem 5: Partners do not always provide (or are not always asked to provide) effective, appropriate and adequate technical support

Note: Technical Support (TS) is the issue that was covered in the first Round Table, RT1. TS-related problems and recommendations are discussed in the subsequent Aidspan white paper *"Providing Improved Technical Support to Enhance the Effectiveness of Global Fund Grants"*, available at www.aidspan.org/aidspanpublications.

# Chapter 3: Factors *at the Global Fund level* that are preventing adequate scale-up to meet the need

**Repeated note re Chapters 2 and 3:** The problems in these two chapters were identified during the pre-RT2 interviews that Aidspan conducted in person in Burundi, DR Congo, Kenya, Nigeria, Rwanda, Uganda and Zambia, and by email with RT2 invitees. In these interviews, people were asked "What factors at the country level [Chapter 2] and the Global Fund level [Chapter 3] are preventing adequate scale up to meet the need?"

The wording of the question meant that interviewees did not focus on things that are going smoothly, or on why they support the GF as an institution. Some interviewees had a few frustrations; some had many. But not one person expressed regret that their country had applied for, or received, GF grants. The quotes will be misleading if this context is not recognized.

As was promised to interviewees, countries, institutions and speakers are not identified here, and will not be identified elsewhere. The quotes capture the precise sense and tone of what specific individuals said, but are sometimes reduced in length from the actual wording used. The words “we”, “our country”, etc., refer to people in the speaker’s country. Obviously, not all people interviewed will agree with all points captured here.

### Problem 6: The GF proposal development process is long and complex. It is a deterrent.

*Quotes:*

(a) "Every round, the Ministry of Health comes to a standstill."

(b) "Even if the proposal-writing team has seminars and workshops to develop the ideas for a proposal, it won't be acceptable as a proposal unless very high-level experts write it; so it is the proposal of the experts, not of the country."

(c) "Most CCM members who sign the proposal form don't understand it. Especially as time is so short to sign it before it is sent in."

(d) "Applying is really cumbersome; worse than an exam. The GF should pick up information from national strategic plans, rather than taking huge amounts of time from people to write proposals."

(e) "The proposal form changes each year because there are always new board decisions that the form must reflect."

(f) "We did so much work on Round 5 and Round 6 proposals, yet got complete rejection. It's so demoralizing."

(g) "In our country, if one wants to scale up adequately, only NGOs can provide the needed capacity. But many NGOs are excluded by the GF's bureaucratic needs. Maybe in some countries NGOs can do 'GF-speak', but not much here."

(h) "At the time when we could have been preparing a Round 7 proposal, we were working hard on the documentation for Round 4 Phase 2, which was like doing a whole new proposal in terms of the work involved. We couldn't spend time on both."

(i) "The GF is very different from what it was when it started six years ago. Most applications are for continuation, scale-up and expansion. Most applications are from repeat applicants. Yet the process and forms treat all the same."

## Problem 7: There is no TRP feedback until after a decision is made, so iterative improvement of the proposal is not possible

*Quotes:*

(a) "The TRP process is set up to be a pass or fail. All Category 3 proposals are rejected with no opportunity for dialogue. Some form of an iterative process would greatly assist applicants."

(b) "Because the TRP process can lead to 'sudden death', applicants are forced to be risk averse. Consequently, bold and ambitious requests are less likely."

(c) "There isn't a way through the TRP for negotiating the budget downwards of an otherwise good but expensive proposal. This is mainly because there is no dialogue or guidance on ambitious proposals that have merit."

(d) "The sole aim during proposal development is to win a competitive process. Thus many are scared of asking for too much. Many times what a country goes for is based largely on what they think the TRP may accept, not what the country really needs."

(e) "Even on approved proposals, feedback from TRP can kill morale. There is no flexible communication channel through which issues raised by the TRP can be addressed."

(f) "We want the approach used by some other donors, where they come and work through with you what is needed and what to do."

(g) "We feel that non-English-speaking countries are more likely to fail than English-speaking countries, because of proposal translation problems."

(h) "One item in the TRP's response to a Round 7 HIV proposal said 'Equity issues between different ethnic groups and feasibility of implementation given persistent insecurity are not sufficiently addressed in the proposal.' This comment led to considerable anger, and was even discussed in the media. In our country, people from the two main ethnic groups live in all parts of the country, they speak the same language, and they have names that do not reveal their ethnic group. It is insensitive, offensive, and impractical to suggest that treatment etc. should take into account a person's ethnicity. How can we respond to ill-informed points like this? To tell us nothing until we are rejected, and only then to give us the reasons, some of which are plain wrong and others of which we could discuss if it weren't too late. It makes us feel impotent and ill-inclined to go through this again."

## Problem 8: Some of the GF's rules for grant implementers are too burdensome, or they are enforced in too rigid a manner. The transaction costs of dealing with the GF are too high.

*Quotes:*

(a) "The GF originally felt like a partner. But now it feels like a donor."

(b) "Within the GF, the big guys say 'be bold'; but then some of the questions that the GF's Fund Portfolio Managers (FPMs) ask are petty. Each response by us triggers more questions from them. They delay sending disbursements because of petty requirements."

(c) "We [a PR] have five ongoing GF grants. With these grants, in the course of nine months, we have had to deal with Phase 2 renewal for two grants, RCC for three grants, quarterly reporting, Round 7 proposal development, ongoing LFA issues, CCM meetings, GF workshops. We have no time to think; no time to implement; we are just dealing with the GF and GF issues."

(d) "The GF expects us [a large SR] to report in ridiculous detail about multiple indicators. A few key indicators would enable us to tell the GF how the grant is progressing. The PR asks 'How many community leaders did you reach? What are their names, their signatures, their phone numbers?' There are almost no roads in our country. Some health centres have phones, but no email. Others are in zones with no phones at all. The only way to get the data is in person; the only way to do this is by plane plus motorbike."

(e) "We understand that in [a neighbouring country], it's permitted to use GF money for human resource incentives and staff retention; yet it's not permitted here. Why?"

(f) "I [the head of a PR] prefer the concept of the GF to that of PEPFAR. But it's easier to deal with PEPFAR."

(g) "The GF must change just like national strategic plans have to change, in response to realities."

(h) "The GF is the victim of its own rules. The GF can't say 'It's OK to estimate', because some will then totally fabricate."

(i) "We would like the GF to be more flexible, and to analyse and understand why the results were not achieved. Instead, they just put pressure on us to achieve the results."

(j) "Due to the problems of recent years in our country, we have lost much capacity. The plans we put forth in the original proposal do not reflect the realities that exist now."

(k) "GF grants are supposed to be country led; but if that was really happening, the grants would evolve to reflect evolving realities."

### Problem 9: GF Fund Portfolio Managers (FPMs) have high turnover and sometimes lack experience

*Quotes:*

(a) "For an entire year, there was no experienced FPM in place for our country. Someone left, then there was a gap, then there was a new one who was learning, then that person left, then there was a gap, then there was another new one who was learning."

(b) "The high staff turnover at the GF is infuriating. We explain things over and over again to new FPMs. There is poor handover from one FPM to the next."

(c) "The number of countries given to each FPM should be reduced. They seem overwhelmed, and this reduces the quality of their work."

(d) "The GF should have some specialized FPMs who have worked with or in problem countries."

### Problem 10: Difficulties arise because no GF people are based in-country

*Quotes:*

(a) "The problem is that the GF people who call the shots are not here. World Bank and DFID and USAID have people here who have been granted power to make decisions. I can go and meet with them and sort out what to do. But with the GF, I can't."

(b) "If there is a change in the national strategy, the CCM has to make a strong case to the GF in Geneva regarding the need to reprogram in line with the new strategy. This would be much easier to discuss if there was a GF office here."

(c) "If the GF had someone here, it would be empowering for the country, not controlling."

### Problem 11: There is poor alignment between GF cycles/systems and national ones

*Quotes:*

(a) "GF requirements and structure are not aligned to country systems. This creates parallel systems that strain national systems and thus hinder any hope for scale-up. The GF budget cycle and the government budget cycle differ. Thus no concrete planning can be made regarding use of GF money."

(b) "It is GF reporting and M&E systems that need to be streamlined into national reporting systems, not the other way around."

### Problem 12: The GF sometimes does not cooperate adequately with in-country partners

*Quotes:*

(a) "Partners in-country try to coordinate and harmonize, discussing things like how technical support will be handled, but the GF is outside this whole framework. In one short period last year, our country had four or five GF-related missions of consultants coming to ask similar questions, and the UNAIDS office knew nothing about it, and there were many duplicative questions. This in a country with a severe HR shortage. It's just so old fashioned having GF people saying 'we're just asking about GF issues'."

### Problem 13: There are problems with Local Fund Agents (LFAs)

*Quotes:*

(a) "Our LFA is based in Mauritius; we are the other side of Africa. They come every three months – but just to audit, not to guide/help/mentor. We need both."

(b) "LFAs look at financial issues instead of integrating a health/technical perspective into their review; and they don't consult with us when in doubt."

(c) "The role of the LFA is not clear and in some countries they are seen as the enemy. There is no communication with the CCM or guidance provided when issues of concern are identified."

(d) "There are big delays when the LFA reports to its own head office in another country before that report is sent on to the GF."

*The author received the following unsolicited email just before this white paper went to press. It is reprinted with permission.*

18 April 2008

Dear Bernard,

The Global Fund is the world's most important public health funding mechanism and it will likely be a model for other multilateral funding mechanisms. It has saved many lives and will save many more. I am an unequivocal supporter of the Fund and I therefore write this as constructive criticism so that the Fund can improve.

The Treatment Action Campaign (TAC) in South Africa is a Sub-Recipient of GF funds. The GF is far and away the most complicated funder that I have ever dealt with (even more so than the EU). It is so complex that it has spawned an industry of expensive consultants with far too much power over the recipient organizations, even though their role is merely to manage the Fund's highly specific technical details. This cannot be right. TAC has far more technical expertise available to it than the vast majority of African NGOs, yet we are struggling to make sense of the GF mechanisms, made even more complex by the fact that our Principal Recipient is the South African Department of Health. I cannot imagine how much more difficult the entire process must be for many other NGOs.

Incidentally, because we were never completely sure we would receive the grant, we accepted other funding for parts of the critical work covered by the GF proposal. Once the GF money came in, we had to go to great effort to negotiate with our other funders to reallocate their funding elsewhere to avoid double-funding. Also, the GF money reached us in February, but their accounting period with us starts in January, which meant we had to reallocate a whole bunch of our January expenses. The accumulation of these small (and not so small) burdens is very difficult for an NGO to manage. Much of this was probably the PR's fault, but the dependency on the PR chosen by the CCM is part of the GF mechanism that needs to be addressed.

Now that Round 8 has the possibility of supporting Community Systems Strengthening, it is critical that the GF massively simplifies its processes, both for applications and for reporting once the monies are disbursed.

Multilateral institutions often fall into the trap of thinking that incredibly complex systems guard against corruption and improve accountability. But in practice unnecessary complexity sometimes reduces accountability and increases the risk of corruption. As an example, I have personally witnessed this with a UN grant we once were involved with in which a TAC staff member worked the UN system to steal money. We had to reimburse the UN, fire the staff member and litigate against him for the stolen money. Five years and dozens of wasted person-hours later we're still trying to recover the money, having spent more on legal fees than the amount he stole. And frankly, from the beginning it was the UN's fault for having such ridiculously complicated disbursement systems in which our former dishonest staff member found a great big hole. The GF must avoid the same trap.

Regards
Nathan Geffen
TAC Policy Co-ordinator
South Africa

# Chapter 4: Major recommendations to the Global Fund

In this chapter, where we present our major recommendations, and also in Chapter 5, where we present other recommendations, we have directed all our recommendations at the Global Fund. We recognize, of course, that multiple actions are also needed by other players – governments of implementing countries, civil society and private sector groups within implementing countries, donors, technical agencies, etc. – sometimes acting independently and sometimes acting jointly with the Fund. But the focus of this white paper is on what the Global Fund can do, so that is how we have structured the recommendations.

What follows is a "menu of recommendations". These are not "either/or" recommendations; in our view, the more that are implemented, the better. However, with some recommendations, the precise form that the recommendation should take will depend upon whether or not certain other recommendations have been implemented.

## Recommendation 1: Significantly enhance GF support for Health Systems Strengthening (HSS)

*Preamble:*

Many developing countries have extremely serious capacity constraints and weaknesses in their health systems, particularly with regard to numbers of staff, training of staff, information systems and physical infrastructure. The term “Health Systems Strengthening” (HSS) is the broad term used to describe initiatives to tackle these capacity constraints and weaknesses.

In Rounds 1-4, the GF sought proposals that primarily focused on financing HIV/TB/malaria-specific programs ("A" in the diagram below).

Then it became clear that in many countries, it was not possible to scale up these programs beyond a certain point unless the country first invested in its health systems. (As in "We can’t do any more on AIDS while the fridges aren’t working and there is no health information system”.)

Accordingly, in different ways in Rounds 5 through 8, the GF also welcomed proposals that invested in HSS ("B" in the diagram below), but only in cases where those investments supported HIV/TB/malaria programs ("A"), and where part of the proposal was for "A" itself. [1] If the HSS investments also happened, "in passing", to support some non-HIV/TB/malaria programs ("D"), that was an acceptable side-benefit.

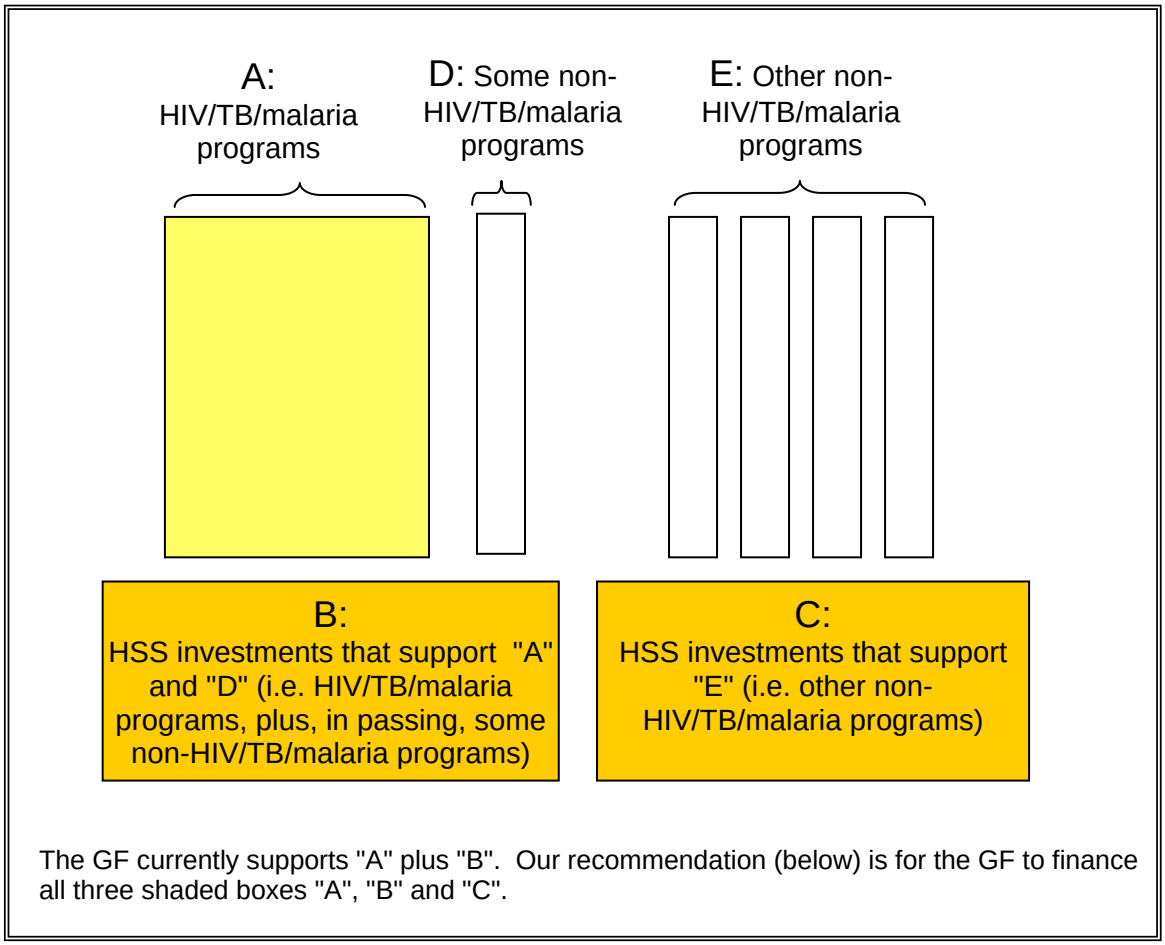
And then it became clear that some countries are unwilling to invest significantly in HIV/TB/malaria programs ("A") plus the associated HIV/TB/malaria-oriented HSS investments ("B"), because that leads to a significant imbalance between those activities and the much-less-supported other components of the public health system ("C" and "E"). (As in “We can't do any more on AIDS while kids are dying of diarrhoea – we need to balance our priorities”.)

Thus, the willingness and ability of countries to significantly scale up their HIV/TB/malaria programs will be severely curtailed unless they have the resources that permit them to invest in all types of HSS activities, and in a range of non-HIV/TB/malaria programmatic activities.

[1] In fact, for Round 5 only, the GF did accept "standalone HSS" proposals.

It is time, therefore, for the GF to go beyond primarily supporting HIV/TB/malaria programs ("A"), to also supporting all types of HSS investment ("B" and "C"). It will then be up to the countries themselves, and other donors, to finance non-HIV/TB/malaria programs ("D" and "E").

Diagram: Types of investment supported by the Global Fund and others [2] [3]




*Recommendation:*

The GF should launch a major initiative whereby it explicitly and enthusiastically welcomes proposals that involve HSS investments of all kinds. Specifically, at its November 2008 meeting, the Board should determine that as of Round 9, applicants will be able to submit not just one HIV application, one TB application, and/or one malaria application, but also, or instead, one HSS application.

Each HSS application should demonstrate that it strengthens and expands the country's health systems in ways that permit improvements in the effectiveness and scale of (a) programs that tackle HIV/TB/malaria and/or (b) non-HIV/TB/malaria

[2] This diagram inevitably simplifies things. For instance, it is not always clear whether salaries should be treated as part of "HSS" (B, C) or "programs" (A, D and E).

[3] Sometimes, B and C are referred to as "horizontal" investments, and A, D and E as "vertical" investments. Certain combinations of these have also recently been referred to as "diagonal" investments.

programs. [4] Permitted HSS expenditures should include salaries, salary top-ups, and staff training programs.

The GF should heavily publicize this key development as soon as the board decision is made, and should then encourage countries to commence their planning for such applications many months before the relevant Call(s) for Proposals.

Note:

1. We are, in effect, recommending that the GF work, with others, in financing the three shaded boxes "A", "B" and "C" in the diagram above. We are not recommending that the GF finance investments in non-HIV/TB/malaria programs (the non-shaded boxes "D" and "E" above). Those should be funded primarily by the countries themselves, possibly with additional support from donors other than the GF.

2. The GF should have strict co-financing requirements, to drive home the point that countries cannot ignore their Abuja commitments (when applicable) of spending 15 percent of their national budget on health if they wish to receive substantial GF funding for HSS.

## Recommendation 2: Dramatically reduce the administrative burden associated with implementing multiple GF grants, and simplify the processes for extending or expanding well-performing grants, by moving towards one "single-stream grant" for each country/disease/PR combination

*Preamble:*

Some PRs have to administer as many as five GF grants for a single disease. As a result, these PRs and their CCMs find that they have been "punished for success", which in turn means they are sometimes hesitant to take on further grants. Unless the GF introduces a dramatic grant consolidation and simplification process, this problem can only become more acute over time.

In addition, processes for Phase 2 renewal, and for extending or expanding existing GF grants, are almost as complex as the original proposal application process.

*Recommendation:*

The GF should no longer require a CCM to go through the entire Round-based application procedure if the CCM is satisfied with its existing PRs for the disease in question. And it should scrap the Phase 2 renewal procedure and the Rolling Continuation Channel (RCC) procedure. Instead, the GF should move towards having, on an open-ended basis, just one "single-stream grant" for each country/disease/PR combination, extendable and expandable as and when agreed, as follows:

[4] A reviewer of this white paper made an astute comment at this point. He said "I feel that at times it is almost as if advocates for the GF are grudgingly saying that the GF will have to do more HSS simply as a means to facilitating AIDS/TB/malaria scale up. Whereas surely it should be about wanting to fight AIDS/TB/malaria so as to meet our public health and development objectives? After all, successful strengthening of health systems should make it possible to contribute to the MDGs not only in relation to AIDS/TB/malaria but also more broadly."

(a) The GF should provide CCMs with a relatively simple procedure for requesting an increase in the scope, size or duration of an existing well-performing grant.

Note: This is equivalent to someone who has a loan from a bank being able to apply to have the loan be made larger or last longer. In the case of the GF, the time from submission of the request for additional or extended funding to the flowing of the resulting new funding (if approved) should be no longer than six months. Of course, just as a bank will not always agree to a request for expanding or extending a loan, so the GF should not always agree to an equivalent request.

(b) The GF should increase Phase 1 to five years and eliminate Phase 2.

Note: In line with this, PRs should be told that although the approval is for five years (potentially extendable), the GF's formal funding commitment at any point is for the following two years, or possibly less if the GF chooses to terminate the grant for persistent poor performance.

(c) Where a particular PR has more than one grant for a particular disease, the GF should move steadily towards consolidating all such grants into one grant.

Note: This means that if a particular PR currently has, say, three malaria grants, that PR will end up with only one malaria grant. And if the CCM of that country wishes to apply for further malaria grants to be administered by the same PR, the CCM would simply apply for additional malaria funding for that PR, as per (a) above.

(d) Arising from the GF's "dual track" policy, the GF should move to having, for each country and disease, two single-stream grants, one with a governmental PR and one with a non-governmental PR. [5]

(e) Without waiting for completion of the above steps, the GF should encourage its partners to identify and fund one or more specialist technical support providers who can, upon request, help countries with the technical aspects of consolidating multiple GF grants into one larger one.

### Recommendation 3: Improve the applications process by introducing a quarterly cycle for accepting proposals, and by extending the time allowed for proposal development

*Preamble:*

At present, countries only have one opportunity per year to apply for GF grants, meaning that the grant's start date often does not align well with the government's budgeting cycle. And the relatively short time between the Call for Proposals and the proposal deadline means that proposals are usually developed on a rushed basis, with minimal opportunity to consult among CCM members and with outside mentors regarding what it should cover. [6]

[5] In some situations, there might be more than two single-stream grants, in cases where there was more than one governmental PR and/or more than one non-governmental PR.

[6] The fact that the proposal is often developed on a rushed basis can't all be blamed on the GF. Even with present structures and timetables, there is nothing to stop a CCM commencing its planning for a proposal long before the official Call for Proposals.

*Recommendation:*

The GF should introduce a quarterly cycle for accepting proposals. The recommended time-span during which the proposal is developed by the CCM should be extended. And the GF should offer an optional Pre-Proposal Form. As follows:

(a) The GF should have two types of application form: An optional Pre-Proposal Form, and a Full Proposal Form. Only the Full Proposal Form should be submitted to the Fund.

(b) The Full Proposal Form should be similar to the current proposal form, though somewhat less complex.

(c) The Pre-Proposal Form should be much simpler, covering the following areas:

- What do you want to achieve with your GF proposal?
- What activities will this involve?
- What indicators and approximate targets are you considering?
- How much do you estimate it will cost? How do you compute that cost?
- What organizations or organization types are you considering as PRs, SRs, and ground-level implementers?
- What implementation-level technical support will you consider seeking?
- What have you done or will you do about problems with previous GF grants?

(d) The GF should recommend that the CCM proceed as follows:

(i) Solicit in-country submissions concerning the content of the CCM proposal (as currently required).

(ii) Decide what the eventual proposal should focus on, and, preferably, who the PR(s) should be.

(iii) Complete the Pre-Proposal Form to capture and help clarify current thinking. Circulate this widely among CCM members; and, if desired, share it with the Pre-Proposal Mentoring Panel (discussed in the next Recommendation). (Note: The TRP will not see the Pre-Proposal.)

(iv) Seek technical support to advise on the writing of the Full Proposal (if required).

(v) Complete the Full Proposal Form.

(vi) Once the CCM is satisfied that the Full Proposal is complete and worthy of submission, submit it in the next quarterly GF cycle. If the whole process takes longer than expected, simply submit the proposal in the following quarter.

Note:

1. The GF will no doubt amend the Full Proposal Form from time to time. But the CCM should be permitted to submit its proposal using any version of the Full Proposal Form that has been in place during the 12-month period prior to the submission of the full proposal.

2. If and when the "single-stream" approach specified in the previous Recommendation has been fully implemented, the whole process discussed

in this recommendation will only have to be carried out when a new country/disease/PR combination is being considered.

## Recommendation 4: Encourage the establishment of a *Pre-Proposal Mentoring Panel*

*Preamble:*

CCMs and others applying to the GF often wait until after the March 1 Call for Proposals before considering whether to apply, what to apply for, and how to obtain technical support regarding proposal development. Also, when they use a consultant to help with proposal development, they are often far too dependent upon the opinions and strengths/weaknesses of a single consultant, and they have no time to obtain a second opinion. Implementation of the following recommendation will provide an incentive for applicants to develop the key concepts for their proposal long before the GF's March 1 Call for Proposals, and will provide applicants with a team of independent mentors with whom they can discuss those concepts. (Note: Some of these timing considerations will be less of an issue if Recommendation 3 is implemented; but the value of the following Recommendation still applies.)

*Recommendation:*

The GF should encourage some neutral outside entity to establish, and other entities to fund, a *Pre-Proposal Mentoring Panel (PPMP)* [7] that is entirely independent of the GF and has no formal powers. The PPMP should be composed of technical experts (including former TRP members), some of them freelance and some of them employed by agencies and organizations that are willing to have them spend some time on this work. Some of them should be South-based employees of existing PRs and SRs. The objective of the PPMP should be to enable potential GF applicants to have a "discussion" with mentors about their ideas for a forthcoming proposal to the GF.

The PPMP should invite potential GF applicants to fill in and submit to it, in confidence, a very simple "pre-proposal" form as discussed in Recommendation 3.

The PPMP should accept pre-proposals for review at any time up to five months before the not-yet-written Full Proposal has to be submitted to the GF. The PPMP should promise to respond to each pre-proposal with detailed comments within one month of receipt. (There could also be a conference call between the PPMP and those who submitted the pre-proposal.) Pre-proposals submitted early enough can be resubmitted to the PPMP, after further work, for a second round of comments. Thus, even after the entire cycle of submitting pre-proposals and receiving comments has been completed, the applicant should still have at least four months to develop its Full Proposal.

The key role of the PPMP would be to advise whether the activities in the pre-proposal appear to be appropriate, implementable and clearly thought through, and whether they come across as something that truly reflect the desires of the country, rather than as something designed purely "to please the TRP".

In situations where the PPMP has reviewed the Pre-Proposal within the time frame just specified, the applicant and the PPMP might agree that the PPMP will also review the draft Full Proposal once the applicant has completed it.

[7] This could, alternatively, be called a *Pre-Proposal Peer-Review Panel (PPPRP)*, but that is such a mouthful that it will probably only cause confusion.

Obviously, the applicant would be free to make its own decision regarding whether/how to make use of the comments received from the PPMP.

The PPMP should not assist in writing the Pre-Proposal or the Full Proposal. And individual PPMP members should commit that (a) they will not accept paid work helping any GF applicants with proposal development until at least one year after their work with PPMP ends; and (b) they will make no attempt to communicate with TRP members regarding countries that the PPMP has helped.

## Recommendation 5: Establish a two-step proposal-approval process

*Preamble:*

At present, applicants are often hesitant to submit a bold proposal because of their fear that the TRP may recommend rejecting it because its scale is too great, or because most aspects are well thought out but one or two are not. The following recommendation will enable applicants to submit bold proposals knowing that the TRP can let them "fix" or remove aspects that the TRP is nervous about.

*Recommendation:*

The GF should establish a two-step proposal approval process as follows. [8] (The timing specified will become more flexible if Recommendation 3 is implemented.)

***Step 1: For all proposals:***

(a) The applicant (usually a CCM) should develop and submit a full proposal during March to June, as at present.

(b) Then, by October 1, the TRP should send the Board its comments on the proposal, together with one of the following:

- A Category 1 or 2 approval recommendation (as at present).
- A Category 3A "fix and resubmit" recommendation, permitting the applicant to move to Step 2. (See Note below.)
- A Category 3B "try again next year" recommendation. [9]
- A Category 4 rejection recommendation (as at present).

Note: In its comments on Category 3A proposals, the TRP should go well beyond briefly commenting on the strengths and weaknesses of the proposal. It should expand these comments, and should also, when applicable, proactively suggest the adding or removing of certain activity areas in the proposal, the increasing or decreasing of activity levels or budgets for certain activity areas, the changing of certain indicators or targets, the removing of a proposed PR and its proposed activities, and more – all so long as the essential goal, approach and flavour of the proposal are not changed. In effect, the TRP would be saying "If we had to make a final decision based on the proposal in its current form, we would recommend rejection. But if you

[8] This process extends to new proposals some aspects of the two-step process currently used for RCC proposals.

[9] Category 3B is similar to the Category 3 that the GF currently uses. It means that the applicant is encouraged to submit an improved proposal in some future Round. However, Category 3B is very different from Category 3A, not just because of the greater delay in getting a Category 3B proposal eventually approved, but because with a Category 3B proposal, the CCM is still expected to invite domestic stakeholders to submit other ideas for consideration in that future Round, and the CCM then has to use a possibly revised application form. Thus, there is not much difference between Category 3B and Category 4.

resubmit in three months after making carefully considered changes in the ways we propose, we might well recommend approval."

(c) In early October, within a week of the Board being informed of the TRP's recommendation and comments, each applicant should be informed (a) of the TRP's recommendation and comments regarding its proposal, and (b) that the Board will, at its November meeting, confirm (or not) the TRP's recommendation. [10]

***Step 2: For proposals receiving a Category 3A decision in Step 1:***

(a) The applicant should be given until the end of January to revise and resubmit its proposal. [11]

(b) In late February, after any necessary translation of the proposal into English, the TRP should rapidly review the revised proposal, and pass it to the Board with a Category 1, 2, 3B or 4 recommendation, as defined above. There should be no Category 3A option this time.

(c) The Board should make a final decision regarding these proposals at its April meeting.

Note: If the Board approves this new two-step approach at its 17th meeting in April 2008, it will be possible for it to take effect in Round 8.

## Recommendation 6: Participate in, convene, or lead a global discussion on what institutional architecture is most suited to achieving the increases in funding and programs that are needed to achieve the health-related Millennium Development Goals, and in particular whether there should be a "Global Health Fund"

*Preamble:*

If dramatically-increased amounts of Health Systems Strengthening do not take place over the next few years, many developing countries – maybe most – will have no hope of reaching "universal access" in the foreseeable future; nor will they reach the health-related millennium development goals by the agreed-upon target date of 2015.

What needs to be decided is (a) who should finance the needed HSS activities, and (b) who should finance the focussed public health programs (e.g. provision of ARVs, tackling of childhood diarrhoeal disease, etc.) that are necessary now but that, even if funding is available, become fully possible only once the needed HSS activities have taken place.

Clearly, a leading funder needs to be the governments of the countries themselves; and the Abuja target of African countries spending 15 percent of their national budget on health was intended to help address this. But few if any African countries are on

[10] Although the GF might be hesitant to inform applicants, before the Board meeting, what the TRP is recommending to the Board, it should be noted that as things currently stand, applicant countries that happen to have a representative who is a board member, alternate or focal point are placed at an unfair advantage over other applicants, because they know what the TRP has recommended several weeks before other applicants do.

[11] This means that the applicant has less than three months from the November board decision in which to make the revisions to the proposal. This includes the holiday season. For this reason, it is necessary to give the applicant a "head's up" warning, in early October, of what the TRP has recommended to the Board. The applicant will be informed that lobbying the TRP or Board is unacceptable, and that the Board has rarely, if ever, made a decision different from the TRP recommendation.

target for this, and, in a very distressing development, some of their governments seem now to be changing their minds regarding their Abuja commitments.

Thus, domestic expenditure by the countries themselves will not, for a very long time, be sufficient in the health area without significant infusions of additional money.

The logical development, therefore, is for there to exist some kind of *Global Health Fund* that provides substantial funding for HSS and program-specific activities, until such time as the countries can cover most of the relevant needs.

Theoretically possible options include having the GF evolve into being a Global Health Fund; having an additional Fund created to tackle areas not funded by the GF; and having the World Bank expand sufficiently to enable it to play the latter role.

But while these options are being discussed and decisions are being made, the GF must not be static. Some institution must, even if only on an interim basis, provide forms of funding that are at present largely lacking.

*Recommendation:*

During 2008-2009, the GF should enthusiastically participate in, convene, or lead a global discussion on what institutional architecture is most suited to achieving the increases in funding and programs that are needed to achieve the health-related Millennium Development Goals.

Options to be considered should include having the GF evolve into being a *Global Health Fund;* creating a separate "HSS Fund" (on a standalone basis, or within the World Bank); and creating a "virtual *Global Health Fund*" around bilateral aid within an existing mechanism, such as the International Health Partnership-Plus framework.

This discussion must be concluded and decisions made by the end of 2009, so that the GF's role in the new global health aid architecture is clear and accepted before the third Global Fund Replenishment Meeting in 2010, where donors will gather to discuss how much they will give to the GF for the years 2011-2013.

Whichever architecture is eventually agreed upon, the GF should insist that the architecture reflects the GF's model of country-ownership and of inclusion of civil society at all levels of decision-making.

And while all this is being resolved, the GF should play a significantly expanded role regarding the financing of HSS activities, as is discussed in Recommendation 1.

# Chapter 5: Other recommendations to the Global Fund

## Other recommendations regarding proposals

*Preamble:*

The GF's proposal form is widely regarded by applicants as being too long and complex, requiring extensive assistance from outsiders who have "a PhD in GF proposal-writing".

Recommendation 7: Learn from the application forms of other funders

The GF should hire a consulting firm to review the application forms used by other major funding entities (including PEPFAR, World Bank, and Millennium Challenge Account), and to then recommend ways in which the GF might be able to simplify its application form. [12]

Recommendation 8: Encourage partners to provide financial support for proposal development

The GF should encourage its partners to create a pool of money that applicants can apply for to support the cost of proposal preparation – with funding being provided on condition that initial proposal planning starts several months before the Call for Proposals, rather than some time after the Call.

Recommendation 9: Seek clear planning from partners re the provision of technical support for proposal development

The GF should encourage UNAIDS, WHO, Stop TB, Roll Back Malaria and other partners to each develop and publish rolling three-year plans for their strategy to support the development of strong proposals to the GF.

Recommendation 10: Accelerate work on the concept of National Strategy Applications

The GF and its partners should significantly accelerate their work developing the concept of National Strategy Applications. The concept was approved one year ago, but the preparatory work by the GF and others is still under way and may not be completed even a year from now. [13]

## Other recommendations regarding CCMs

*Preamble:*

CCMs are a key and innovative part of the GF architecture. A few CCMs function well, a reasonable number function moderately, and quite a number function poorly or badly. Despite this, only three out of ninety-six Round 6 proposals and three out of eighty Round 7 proposals were "screened out" as a result of non-compliance with GF requirements. Thus, there are at present very few negative consequences for CCMs that are technically compliant but still function poorly or badly. If the bar is raised somewhat for CCMs, this might have a temporary negative impact on the

[12] Of course, other large donors often have a representative in-country who can work with the applicant on steadily refining the proposal; they also often provide their own technical support. So it will be hard to make the GF application form as simple (relatively speaking) as the ones used by those donors.

[13] Background: In April 2007, the GF board agreed to move to supporting applications for funding to support national strategies, in cases where the strategy (a) is inclusive, costed, comprehensive and prioritized; (b) includes a workplan and budget; and (c) has successfully undergone a rigorous technical certification by an "independent review mechanism".

ability of countries to scale up, but in time it will lead to fewer dysfunctional CCMs and therefore more bold proposals and grants.

Separately: If the GF wants each CCM to perform effective oversight over grants and to fully embody a public-private partnership, the CCM Secretariat needs to be independent (rather than hosted/staffed by a government entity, as often is the case), professionally staffed, and adequately funded.

Recommendation 11: Establish a tougher "screening out" process

The GF Secretariat should divide its "screening out" process into two parts, and then toughen up the first part, as follows:

*Part 1*: During the second half of each year, the GF Secretariat should, for each CCM:

(a) determine whether that CCM is in compliance with all three of the following existing GF requirements:[14]

- "CCM members representing the non-government sectors must be selected or elected by their own sector(s) based on a documented, transparent process, developed within each sector."
- "CCMs must show evidence of membership of people living with and/or affected by the diseases."
- "When the PRs and chair or vice-chairs of the CCM are from the same entity, the CCM must have a written plan in place to mitigate against this inherent conflict of interest."

(b) determine whether that CCM has provided the GF Secretariat with sufficient information to enable the Secretariat to post complete and accurate information at the GF website regarding all CCM members, which sectors they represent, and their contact details.

If, by the end of the year, the above conditions have not been fully met, the GF should publicly announce that the CCM in question is not permitted to submit applications to the GF during the subsequent year, and that non-CCM applications from the country in question will be considered.

*Part 2*: Upon receipt of each proposal from a CCM that has passed the "Part 1" process above, the Secretariat should, as at present, ensure that the CCM has been compliant with the following existing GF requirements:

- "CCMs are required to put in place and maintain a transparent, documented process to solicit and review submissions for possible integration into the country coordinated proposal."
- "CCMs are required to put in place and maintain a transparent, documented process to ensure the input of a broad range of stakeholders, including CCM members and non-members, in the proposal development and grant oversight process."
- "CCMs are required to put in place and maintain a transparent, documented process to nominate the PR and oversee project implementation."

[14] These requirements have all been in effect since at least June 2005.

Applications from CCMs that do not meet these conditions should, as is currently required, be screened out.

Recommendation 12: Publish CCM Scorecards

Each year, the GF should develop, and publish at its website, a "CCM Scorecard" for each CCM, showing how effectively the CCM in question functions with respect to the GF's various "requirements" and "recommendations" regarding CCM composition and performance. Members (not just leaders) of the CCM, and other observers in-country (from donors to activists), should have the right then to post publicly-viewable comments regarding these scorecards.

Recommendation 13: Clarify the meaning of "CCM oversight over grants"

The GF Board should provide clarification regarding what it means when it says that CCMs should play an "oversight" role over grants, particularly in the very common situation where a number of CCM members also serve as PRs or Sub-Recipients. (This clarification should consist of guidance/advice, but should not be a new "CCM requirement".) The GF Secretariat should then provide tools to help CCMs to perform their oversight role effectively.

Recommendation 14: Provide increased funding for CCM operations

In countries that are large, or that have many grants, or where the CCM wishes to have an independent professional CCM Secretariat that is not hosted/staffed by an existing large institution, the GF should be willing to provide considerably more than the current ceiling of $43,000 per year for funding the operations of the CCM.

Recommendation 15: Seek mentoring assistance for CCM Secretariats and local watchdogs

The GF should encourage one or more qualified neutral outside entities to offer mentoring and training:

(a) to CCMs and individual CCM members, and to interested in-country and regional civil society groups and media entities, on how to play a constructive and effective oversight or watchdog role regarding the implementation of GF grants;

(b) to CCM Secretariats on how to conduct their operations in a professional and neutral manner.

Recommendation 16: Encourage the formation of Sub-CCMs

The GF should actively encourage the formation of Sub-CCMs in specific large federated states where a single national CCM has difficulty representing the entire country.

## Other recommendations regarding support for implementers

*Preamble:*

Implementers often find that GF staff are overworked and provide insufficient mentoring and grant reprogramming support, particularly when grants need to be adapted to take account of evolving situations in-country.

Recommendation 17: Recruit more Fund Portfolio Managers

The GF should recruit more Fund Portfolio Managers (FPMs), thereby enabling each FPM to have fewer countries to deal with (or even only one country, in certain

arduous cases). The GF should also make a point of recruiting some FPMs who have specific experience working in post-conflict and fragile states.

Recommendation 18: Encourage LFAs to provide more mentoring in certain circumstances

The GF should ensure that in the course of orienting LFAs, it encourages them to sometimes go beyond their financial and programmatic oversight role, so that they also provide modest amounts of mentoring to PRs regarding (a) communication difficulties with the GF, (b) reporting to the GF, (c) reprogramming, and possibly (d) broader grant implementation difficulties.

## Other recommendations regarding GF communications

*Preamble:*

A surprising number of people who are CCM members or who work for PRs and SRs have significant misconceptions about the GF. Also, many people are unaware of current or forthcoming major opportunities offered by the GF (such as Regional proposals and National Strategy Applications).

Recommendation 19: Tackle common misconceptions

The GF should formulate a communications strategy that tackles and corrects various common misconceptions about the Fund that have been identified within CCMs and among grant implementers. [15]

Recommendation 20: Promote Regional proposals

In some countries, there are multiple civil society and private sector groups that could serve as SRs, but there is no in-country PR that can work with and coordinate them, or there is such a PR but the CCM is not willing to submit a proposal involving this PR.

Accordingly, the GF should actively encourage large regional organizations (including not only international NGOs, but also international labour and faith-based organizations) to consult with relevant CCMs and then to submit regional proposals to the GF. In these proposals, the regional organization would serve as "coordinating PR", arranging for all the implementation work in the various countries to be performed by domestic civil society or private sector organizations serving as SRs. Each SR's role should be in line with national policies of the country in which it is based. The GF should make it quite clear that the approval of such proposals will not reduce the chances of the GF approving standard single-country proposals from individual CCMs within the region in question, so long as there is no program duplication. (Note: Nothing in this recommendation involves a change in GF policy; the recommendation is simply that the GF actively promote an option that is already available under existing GF policies. [16])

[15] This communications strategy could include the GF Executive Director making a DVD presentation in English, French and Russian (and, with voice-over, in other languages) to be made available for playing at CCM meetings.

[16] Starting with Round 8, the GF has provided a special version of its application for use by regional organizations and regional CCMs.

## Other recommendations regarding analysis

*Preamble:*

Before a CCM can make a fully informed decision about what its next GF proposal should focus on, it needs access to a gap analysis that shows, for the country in question:

(a) the estimated number of people who will need certain services (e.g. ARVs, bednets, etc.) by, say, 2010;

(b) the estimated number of people who will receive these services as a result of existing programs funded by the GF, other donors, and domestic entities; and

(c) the gap between these two. (It is this gap that has to be closed when we talk of "scaling up to meet the need".)

At present, the GF requests applicants to provide this information as part of their application to the GF; but that work is sometimes conducted after, rather than before, key decisions have been made by the CCM regarding proposal priorities.

Recommendation 21: Conduct country-by-country gap analyses regarding the needs

The GF should encourage one or more GF partners, during the second half of each year, to develop and publish, for each country, a preliminary gap analysis as defined above. These partners should then offer to provide an in-person presentation to each full CCM regarding the gap analysis for the country in question. (The CCM can then develop and incorporate into its proposal an improved version of this gap analysis.)

Recommendation 22: Conduct a joint analysis with PEPFAR on scaling-up potential

The GF should conduct a joint analysis with PEPFAR on ways in which the maximum number of people can benefit from GF and PEPFAR grants using currently available funding. Once complete, this analysis could be extended to include other funders.

Recommendation 23: Analyse procurement bottleneck issues

The GF should identify which are the countries in which procurement difficulties represent the primary bottleneck to scaling up, and should then work with the Clinton Foundation and others in devising short-term and long-term strategies for dealing with this.

# Appendix: Analysis of institutional policies, practices and plans aimed at "Scaling up to meet the need"

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## A: INTRODUCTION

Recent years have witnessed unprecedented increases in the scale of global efforts to fight AIDS, tuberculosis and malaria, in large part thanks to the creation of the Global Fund. On March 1st 2008, the Global Fund launched its biggest ever funding round, indicating that it is in a position to commit in excess of US$2 billion to successful proposals. Indeed, the Global Fund hopes to be able to further increase the amounts it makes available in subsequent funding rounds in line with projections of what is needed to reach global targets in fighting the three diseases (1).

Despite these welcome developments, there is consensus that current efforts are still a long way from meeting the needs of those at risk from and affected by the three diseases (2; 3; 4; 5). It is widely acknowledged that even if available funding reaches the levels required to

meet the needs associated with the fight against the three diseases, a range of other barriers stand in the way of efforts aimed at scaling up to meet these needs.

This paper provides an overview of the main challenges that are faced by efforts to rapidly scale up the response to the three diseases, and describes the main strategies that major international agencies have put in place to meet these challenges. The paper is based primarily on analyses of challenges and strategic frameworks published by the major global health agencies and partnerships, and is augmented by the results of interviews with senior representatives of some of these agencies[17]. It was commissioned as part of the preparation for the second Global Fund Round Table, on the subject of "Scaling up to meet the need: overcoming barriers to the development of bold Global Fund-financed programs".

# B: SCALING UP TO MEET THE NEED: THE MAIN CHALLENGES

A review of the different analysis and strategy papers produced by the major agencies and partnerships supporting the global response to AIDS, tuberculosis and malaria reveals a fairly consistent appraisal of the general challenges that need to be overcome if global targets for fighting AIDS, tuberculosis and malaria are to be reached. However, there are also some important specificities relating to each of the three diseases. Finally, the Global Fund itself has identified specific issues that relate to its own model. A brief summary of challenges under each of these three categories is provided in this section[18].

## B.1: GENERAL CHALLENGES

The overall challenges to scaling up efforts to fight AIDS, tuberculosis and malaria are well-documented. Some of the most important challenges related to implementation of these efforts can be summarised under two broad, interlinked headings: finance and capacity. The challenges described under "finance" are essentially to do with how external funding for the response to AIDS, tuberculosis and malaria is allocated, planned and monitored. Those described under "capacity" concern the capacity of countries to implement effective, scaled up efforts. A third group is described under the heading "broader contextual challenges".

### *(a) CHALLENGES RELATED TO FINANCE*

The most obvious challenge related to finance is to ensure that sufficient funds are available to support efforts to finance scaled up responses to the three diseases. Significant strides have been made in this direction, for instance with financing of development assistance for health doubling in the period 2000-2005, with considerable proportions of newly available funds being dedicated to AIDS, tuberculosis and malaria (6). The recent announcement by the Global Fund that it hopes to fund over US$2 billion worth of new projects submitted during Round 8, and US Congress plans to re-authorize and substantially increase funding through PEPFAR, are among the positive indications that funding commitments are moving towards the levels required. The concern in terms of availability of funding, however, is not simply that it should quickly reach the levels required for a fully scaled response to the three diseases, but that the support should be sustained, at predictable levels. Uncertainty in relation to future levels of funding can impact on scale up, for instance by discouraging long term systems development and by forcing implementers to be conservative in their procurement of drugs and other essential products. In addition, the current availability of

[17] Documents published by the following agencies and initiatives were reviewed: GFATM, IHP, OGAC-PEPFAR, Roll Back Malaria, Stop-TB, UK government, UNAIDS, US Government, WHO, World Bank. In addition, efforts were made to speak to senior representatives of all of the agencies and partnerships; however respondents were only available from two of these (GFATM and STB).

[18] This section draws on a range of documents published by the different agencies and initiatives – a complete list is contained in the bibliography. References are only provided for specific data and direct quotations.

significant levels of new external funding, combined with this uncertainty, raise concerns over the impact it might have on inflation and macroeconomics in poor countries (7; 8).

Another major challenge is whether the available funding will enable the development and strengthening of health systems which are the necessary backdrop to effective, scaled responses to AIDS, tuberculosis and malaria. In its global HIV/AIDS strategy, the World Bank suggests that an overemphasis on disease-specific programmes can be detrimental to health efforts, stating that "Donor demand for quick and visible results discourages efforts to solve long-term, less visible problems such as weak health systems and lack of health personnel" (8). The major agencies involved in funding AIDS, tuberculosis and malaria programmes have increasingly recognised not only that the success of their efforts is dependent on strengthened health systems, but also that their programmes have the potential to simultaneously develop health systems while focussing on achieving results related to the three diseases (9; 10). As a result, health system strengthening activities increasingly feature in these programmes. However, it has been suggested that approaching health systems strengthening from a disease-specific perspective risks restricting the ability to tackle "macro" health system issues (11); and it is also clear that the resource needs for health systems strengthening are considerably greater than the level of support available through dedicated AIDS, tuberculosis and malaria funding. As the Global Fund points out in its most recent results report, "the cost of human resources training to meet the MDGs alone is estimated by WHO at US$ 92 billion, with US$ 39 billion in recurring costs. The Global Fund cannot achieve sustainable results on its own. Systematic, long-term development of fundamental health infrastructure is urgently required from other donors" (10).

A third area of concern is the increasing diversity and complexity of systems for funding. The existence of a wide array of funding sources, allocated using a variety of mechanisms, can constitute a considerable burden for overall coordination of national programmes, as well as for individual institutions implementing programmes funded from different sources. Coordination of these different inputs is further complicated by the fact that different sources of financial support often come with specific conditions, and with different implementation arrangements, objectives and timelines. Ensuring complementarity between funding programmes that espouse fundamentally different approaches to development – for instance disease specific programmes, health sector approaches, and national budget support – is also very challenging. There are also challenges in ensuring that overall levels of support are balanced according to the needs of each country, as bilateral funding programmes often prioritise their financial and technical support to a limited number of countries. Finally, the complexity and diversity of the funding architecture, and the increasing emphasis on obtaining results directly related to the three diseases, can also mean that important areas are neglected: technical support for scale up in particular, has been referred to as the "unfunded mandate" (12; 13).

### *(b) CHALLENGES RELATED TO CAPACITY*

It is recognised that independently of issues related to finance, efforts to scale up responses to AIDS, tuberculosis and malaria are facing an "implementation crisis" (12). This crisis can be understood in two ways: limited capacity to implement scaled up responses to the three diseases (i.e. capacity in the sense of volume), and limited technical capacity (systems, skills and know-how).

Recipients are often required to handle unprecedented levels of funding, and to implement and report on large-scale and complex programmes: this means new systems for management and monitoring need to be built. However, capacity is also about the ability to deliver on the ground. In many countries, the capacity to provide the volume of services required in order to take the response to AIDS, tuberculosis and malaria to scale is severely constrained. Although this constraint relates to the capacity of health systems and

infrastructures as a whole, it is well illustrated by the critical shortage of health care workers, a shortage which is often most acute in some of the countries most affected by AIDS, tuberculosis and malaria, and which is in some ways exacerbated by the impact of these three diseases on the health care workforce (14). In such contexts, already limited health systems and workforces are being asked to take on additional targets, sometimes, it has been suggested, at the expense of other core health care priorities (6; 15). Health systems in their current form are approaching the limits of what they can do in terms of volume of effort, and because of the time needed to strengthen them (for instance through increased recruitment and training of health care workers), it is difficult to fill this gap as rapidly as required. The challenge is compounded by the fact that very often, the diseases are having the most impact in areas where there is the least capacity to respond.

Technical weaknesses can mean that even efforts that are implemented at scale may not have the desired impact. Poor information systems can affect the quality of planning, of tailoring responses and allocating resources according to needs (7). Indeed, recent data show that many of the highest priority interventions (for instance, prevention of mother to child transmission, prevention with vulnerable groups, and treatment for children living with HIV) are being scaled up at a much slower pace than other components of the response to AIDS (5; 16). Weak technical capacity can also result in ineffective service provision, because essential systems such as those for laboratory diagnosis or for drug procurement, management and supply are not well designed or fully implemented. Service provision can also be ineffective because service providers are not employing evidence based approaches: much tuberculosis treatment fails to adhere to international standards (13); HIV prevention efforts in many efforts are neither comprehensive nor evidence-based (16); and joint HIV-TB activities are not as widely implemented as they should be (4). In these situations, it is crucial *not* to scale up what is already being done, but to introduce and scale up effective, evidence-based approaches.

The analysis here has focused on the well-documented capacity constraints of health systems. It is important to recognise that this term does not just relate to public health systems, but to all of the actors that make up a national health system. In addition, it should be recognised that capacity constraints are equally common in institutions that are not part of the health system. Indeed, they are often more acute in the civil society sector which rarely has a developed physical or professional infrastructure.

### *(c) BROADER CONTEXTUAL CHALLENGES*

In addition to the challenges related to the provision of international financing and to national capacity, efforts to scale up responses to AIDS, tuberculosis and malaria also face broader contextual challenges. Many of the constraints in terms of health systems capacity are caused by more deep-rooted problems related to poverty, governance, weaknesses in education systems, inequalities in access to services and challenging social environments (particularly in relation to gender inequality and the rights of marginalised groups), political instability and lack of political commitment to building health systems and to tackling the diseases as a development priority – indeed, it has been suggested that these issues may constitute barriers that are more important than those related to finance and capacity (11). These contextual challenges make it hard to implement effective programmes, and at the same time they are often among the root causes of vulnerability to the three diseases.

A second set of contextual challenges relate to the environment for development of new technologies to fight the three diseases, in particular diagnostic tools and drugs. Researchers and drug companies do not always have the incentives to develop new products that are appropriate to needs (for instance, drug formulations that are tailored to the needs of children), and continuity of production and supply of existing technologies is not always guaranteed. Insecure supplies jeopardise service delivery and can contribute to drug resistance problems.

## B.2: DISEASE-SPECIFIC CHALLENGES

Each disease has its own challenges, which impact on the feasibility and possible pace of scale up. It is important that global financing strategies and health systems strengthening efforts – particularly those aimed at supporting responses to all three diseases – pay attention to these specificities. A small number of examples are provided to illustrate this.

### *(a) TECHNICAL ISSUES*

The different characteristics of the three diseases mean that for each, there are different priorities in relation to health systems strengthening and development of new technologies. As mentioned above, the development of new technologies for both prevention and treatment is necessary for all three diseases. However, the need for new tools is perhaps most acute in the case of tuberculosis programmes, which will struggle to make the required progress if they have to continue relying on very old diagnosis and treatment technologies. This is all the more important in the context of the increasing spread of drug-resistant forms of the disease. Rapid development of new tools is therefore an essential component of efforts to fight tuberculosis.

One of the primary technical challenges for fighting HIV is the slow uptake of comprehensive prevention approaches which target the right people. Many of the efforts to prevent sexual transmission of HIV that are implemented at scale are limited to awareness-raising, and do not tackle some of the broader determinants of vulnerability and of risky sexual behaviour (16; 17). Efforts to scale up responses to HIV/AIDS also need to establish better integration and continuity between prevention, treatment, care and support and impact mitigation efforts in order to ensure they have a greater impact (16; 18).

A major technical challenge for the fight against malaria is the disease's rapid progression to a stage that is fatal. Treatment within a matter of hours is essential in order to save lives, and this is further complicated by the fact that a high proportion of cases occur in rural, underserved areas. For malaria, one of the main health systems strengthening priorities is therefore the development of capacity to respond more effectively and quickly to emergencies.

### *(b) IMPLEMENTATION ARRANGEMENTS*

Responses to AIDS, tuberculosis and malaria have been developed and implemented by different actors. The response to AIDS has a strong tradition of patient movements, community support, human rights based approaches and multisectorality, but often with poor integration with health services in general and sexual and reproductive health in particular. On the other hand, tuberculosis programmes have tended to be well integrated into health systems but community involvement in treatment is not widely instituted. Meanwhile, responses to malaria have placed a lot of emphasis on availability of products such as bed nets and basic treatments through the private sector (both subsidised and unsubsidised). Although these differences reflect the specificities of each disease and the strategies to respond to them, they also reflect historical trends and popular perceptions of the diseases. It is likely that each disease response can learn from the others how to best make use of the contributions of different sectors and movements.

As the limits of capacity to take responses to the three diseases to scale have become more evident, there has been an increasing emphasis on engaging "non-traditional" actors. This is demonstrated by the Global Fund's recommendation to all Round 8 applicants to adopt dual-track implementation[19], and by the enhanced emphasis in global tuberculosis and malaria strategies on involving civil society organisations in advocacy and social mobilisation

[19] i.e., for each grant to be implemented by principal recipients representing both the government and non-governmental sectors. This recommendation is applied equally to all three diseases.

activities (13; 19). The challenge is to ensure that while new actors are enabled to contribute fully, the role and comparative advantage of each sector with respect to each disease is also recognised.

### *(c) POLITICAL AND SOCIAL CONTEXT*

The contextual barriers are also different for each disease. While AIDS is still not where it should be on the broader development agenda of many countries, it often receives more attention than tuberculosis and malaria. Many countries have multisectoral AIDS coordinating bodies, and responses to AIDS receive additional global impetus through initiatives such as Universal Access and the Three Ones. Although this means that the "architecture" for the response to AIDS tends to be more complex, it also means that malaria and tuberculosis efforts often do not receive the same level of national political commitment.

On the other hand, certain elements of the response to AIDS are still extremely controversial, which means that investments in the response to AIDS are often not used to support the most important or appropriate interventions. As the World Bank puts it: "The social, political and legal climate is often inimical to effective AIDS programming. Populations at high risk of infection are overlooked/underserved because of stigma, taboos and denial, or because governments shy from controversial services or serving marginalised groups" (20). Moreover, there are concerns that even when marginalised groups are targeted, scale up efforts can compromise human rights (21). Stigma in relation to tuberculosis also poses challenges, in particular in terms of recruitment and retention of health care personnel.

## B.3: CHALLENGES TO SCALE UP FROM THE GLOBAL FUND'S PERSPECTIVE

As noted already, Round 8 is the Global Fund's biggest round yet, representing a considerable opportunity to accelerate the pace of efforts to scale up. However, while during some previous rounds there were concerns that requests for funding might exceed the funds available, the concern this time is that the total value of proposals approved for funding at the Global Fund Board meeting scheduled for November 2008 may not be as high as the level of funding available (Personal communication, Christoph Benn, the Global Fund). The potential for this to happen has been recognised for some time, as the Global Fund mobilises funds based on global estimates that are considerably higher than the levels of funding requested in past proposals (2). From the Global Fund's perspective, it is therefore also important to see the challenge as one of insufficient demand for funding from countries. A number of possible explanations are proposed for this: insufficiently ambitious national plans to fight the three diseases; unease on the part of health ministries at the prospect of promoting AIDS, tuberculosis and malaria responses when other health issues are neglected; lack of awareness of the levels of funding available, of options to use alternative service provision mechanisms, and of the Fund's openness to supporting health systems strengthening; and overly complex and conservative systems for allocation of funds by the Global Fund (Personal communication, Christoph Benn, the Global Fund).

# C: INSTITUTIONAL POLICES AND PLANS TO SUPPORT SCALE-UP

## C.1: OVERVIEW OF POLICIES AND PLANS

As previously noted, the nature and scope of the current challenges faced by efforts to scale up the response to AIDS, tuberculosis and malaria are well recognised and documented at global level. The key global level agencies and initiatives reviewed for the purposes of this paper implicitly or explicitly recognise most of these challenges in their current strategic plans or policies. In addition, supporting effective "scale up" is a central goal for all of these agencies, and their strategies reflect this overarching priority, for instance:

- all of them are involved in either providing or advocating for increases resources for the fight against the three diseases
- promoting greater commitment to fighting the three diseases also emerges as a priority in each case
- increased and improved provision of technical support is also a commonly stated priority.

At the same time, each has a particular focus and set of priorities which set their approach apart. This section provides a brief review of the approaches of each institution, attempting to identify some of the key features that differentiate each one.

### *(a) BILL AND MELINDA GATES FOUNDATION*

Through its Global Health Program, the foundation is a large contributor of funding both to programmes aimed at accelerating access to effective services in poor countries, and to research programmes aimed at improving and developing new tools (including vaccines) to support global health efforts. AIDS, tuberculosis and malaria (22) are among the foundation's top priorities for funding, allocated both through directly funded grants and through support to global initiatives such as the Global Fund. Support to delivery of health services is also provided through funding to community health programmes.

The foundation is also active in its direct involvement in and its support to advocacy, for instance on ensuring HIV prevention receives adequate attention in international programmes, on promoting evidence-based programming, and on ensuring that further resources are committed to fighting the three diseases.

### *(b) GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA*

The Global Fund's plans to increase the pace of scale up are primarily outlined in the 2007 strategy document, *Accelerating the Effort to Save Lives* (1). Many of the strategy shifts proposed in this document have begun to be explored further or operationalised, for instance in more recent decisions of the Global Fund board (23), in the Round 8 Call for Proposals. In addition, further options are being discussed internally (Personal communication, Christoph Benn, the Global Fund).

*Accelerating the Effort to Save Lives* outlines three strategic pillars, all of which directly aim to accelerate and improve the Global Fund's contribution to scaling up responses to AIDS, tuberculosis and malaria. These three pillars are:

- Grow to Meet Demand
- Adapt to Country Realities
- Innovate for Greater Impact

The first pillar outlines the Fund's ambitious plans for resource mobilisation, based on estimates of resources needed to reach the global targets for fighting the three diseases. The Global Fund plans to mobilise US$6-8 billion a year by 2010, through increased support from existing donor governments, engaging new donor governments, increasing

contributions through private sector mechanisms, and through other innovative approaches such as UNITAID and debt conversion.

By working to "adapt to country realities", the Global Fund aims primarily so that its own support is aligned with the need to improve donor assistance harmonisation; to address procurement bottlenecks (including improving stability of supply and pricing); and to ensure that its own support to disease specific programmes includes support to health systems strengthening "where it is directly related to AIDS, tuberculosis or malaria" (1).

The innovations described in the strategy aim to further increase country ownership – a core principle of the Global Fund – as well as promoting greater continuity of support and long-term funding and further enhancing the role of non-governmental sectors in the governance and implementation of Global Fund projects. This will be done by making it possible for countries to request funding on the basis of national strategies (rather than proposals), by further facilitating continued funding to high-performing grants, and by promoting the role of non-governmental sectors as implementers and ensuring they receive the support required to be effective in implementation and governance of Global Fund projects.

The Round 8 Call for Proposals reflects many of the adaptations outlined in *Accelerating the Effort to Save Lives*, in particular through changes designed to promote greater attention to health and community systems strengthening, through the promotion of civil society organisations, and through greater attention to issues of inequality (including gender inequality). However, what is less clear is what an increasing attention on systems strengthening will mean in terms of the pace of scale up.

As noted in the previous section on challenges, the Fund has some concerns that "demand" for support (in the form of approved funding proposals) may not grow as rapidly as the opportunities to obtain it: there is a disconnect between demand for funding from countries and needs as assessed by "top-down" estimates (2). The Fund is therefore also exploring ways of promoting demand at country level, by ensuring countries are aware of the opportunities and by encouraging ambitious plans. At the same time the Fund is examining its own processes for allocating funding, in order to facilitate applications and to ensure that promising funding requests are not being turned down unreasonably (Personal communication, Christoph Benn, the Global Fund).

### *(c) IHP+*

IHP+ is an initiative of a number of international health agencies (many of which are included in this review), and builds on various efforts aimed at "Scaling up for Better Health", including the International Health Partnership and the Millennium Development Goals (24). By supporting country analysis of health systems constraints to achieving better health, promoting technical knowledge and good practice, enhancing coordination and harmonisation of support, and monitoring IHP+ efforts (which will target 8 countries to begin with), the IHP aims to address some of the major challenges related to health systems strengthening and harmonisation identified above.

### *(d) Roll Back Malaria Partnership (RBM)*

In the Global Strategic Plan to Roll Back Malaria 2005-2015, the RBM Partnership emphasises rapid scale up focussing particularly on the poorest and most vulnerable (19). As well as promoting the use of appropriate interventions, the partnership aims to increase country level attention to malaria (for instance through greater integration of malaria priorities into PRSPs and advocating the removal of tariffs and taxes on malaria commodities) and to ensure that systems – particularly those that are crucial to an effective malaria response such as procurement and supply chain management – are adequately strengthened. The plan also seeks ways of strengthening multisectoral involvement in the response to malaria, in particular emphasising the potential role of civil society organisations in improving the

environment for effective malaria service delivery: for instance by advocating for increased funding, representing the needs of disenfranchised groups and promoting pro-poor responses, and in awareness-raising to create demand and ensure appropriate use of malaria prevention products.

### *(e) STOP TB PARTNERSHIP (STOP TB)*

The Global Plan to Stop TB outlines the key interventions that a scaled up, effective response to TB should adopt. In order to promote this the Stop TB partnership is paying particular attention to advocating and expanding the accurate use of existing technologies (both in terms of capacity to use the technologies and ensuring their continued affordability and availability), the development of essential new tools for diagnosis and treatment, the mobilisation of financial resources needed to support an expanded response (13). The Partnership also places a strong emphasis on the provision of a full "package" of technical support to TB programmes, rather than technical support being simply a crisis resolution measure. Indeed it has been argued that this planned, coordinated approach to technical support by the Partnership has been one of the key determinants of the strong performance of Global Fund TB grants (25).

Other key areas of focus for the Partnership are the strengthening of health systems and in particular of human resources for health; and the engagement of other sectors in the response to TB, particularly civil society organisations as key actors for the involvement of communities and patient groups.

### *(f) UK GOVERNMENT*

The main documents outlining the UK government's commitments and priorities are DFID's health policy *Working together for better health* (26), and the UK's HIV/AIDS strategy: *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world* (27)[20]. A number of other documents provide additional background (28; 29; 30; 31).

The UK government is a significant contributor of funding to global health programmes, including efforts to fight AIDS, tuberculosis and malaria. DFID provides support to global initiatives such as the Global Fund, IAVI, UN agencies, and disease-specific research efforts. The majority of DFID funding for health is spent via bilateral agreements, and is focussed on a number of priority countries. Although DFID is one of the foremost advocates of budget support mechanisms (both global budget support and sector-based budget support), project based support (both health sector focussed or disease specific) is also employed in many countries. Hence in some countries – such as Malawi – DFID has supported specific initiatives aimed at health sector strengthening and resolving the workforce crisis.

The current health strategy firstly commits DFID to providing more resources for health. Although the strategy does not provide numerical commitments, it primarily emphasises bilateral mechanisms aimed at providing "more flexible, longer-term and increasingly predictable financing for the health sector" including through budget support. The strategy also conditionally commits to supporting multilateral mechanisms "as long as this delivers effective aid through more predictable financing for health; strengthens national health systems; and improves the health status of poor people as a priority".

The second focus for DFID is to work – primarily with partner countries – to expand access to "basic services" through strengthening health systems, and including focussed, evidence based action on HIV and AIDS (with an emphasis on "combined approaches to HIV prevention and on integrating HIV and AIDS with sexual and reproductive health, maternal

[20] *Taking Action* is currently in the process of being updated for the period 2008-2010. At the time of preparing this report, it was not possible to obtain indications of changes in the UK's AIDS strategy.

health and TB services"). Expanding access to services also includes paying attention to the needs of excluded groups and to gender inequalities, for instance through supporting civil society action on rights.

The third focus is on aid effectiveness. A priority for DFID is to ensure that longer term support is provided to health, especially to the delivery of basic services, as a complement to disease specific initiatives. DFID will promote pooled funding approaches and ways of better harmonising and rationalising support to countries. A recent example of work in this area has been the UK's promotion of the International Health Partnership.

Finally, DFID will provide support to research aimed at improving measurement of results and improving the evidence base for health programmes. Particular areas of focus will be on the development of systems "that deliver health services and address priority diseases as well as emerging challenges…", and on development of new technologies and tools, including those necessary for fighting AIDS, tuberculosis and malaria.

### *(g) Joint United Nations Programme on HIV/AIDS (UNAIDS)*

The support of UNAIDS to the process of scale up and to achieving "universal access" to HIV prevention, treatment, care and support is outlined in its *2007-2010 Strategic Framework for UNAIDS support to countries' efforts to move towards universal access* (32). Recognising the numerous challenges faced in the global response to AIDS, the framework outlines 5 strategic directions:

- Guiding the global agenda, increasing involvement and monitoring global progress
- Technical support and capacity building to "make the money work" for universal access
- Human rights, gender equality and reduced vulnerability for most-at-risk populations
- Re-emphasizing HIV prevention alongside treatment, care and support
- Strengthening harmonization and alignment to national priorities

Although it is not feasible to provide a complete overview of UNAIDS' plans, it is useful to illustrate some of the ways the programme contributes to strengthening country-level capacity to scale up and to "making the money work" (the second strategic direction). The Global Implementation Support Team (GIST) is a mechanism for providing an urgent response when external support is needed to resolve bottlenecks, particularly in the implementation of Global Fund grants (33). In another initiative, UNAIDS has established Technical Support Facilities (TSFs) in a number of regions, aimed at improving the provision of timely, appropriate technical support to ongoing projects (34). A third key initiative implemented by the UNAIDS secretariat and cosponsors is ASAP (AIDS Strategy Action Plan), a service to support stronger, epidemiologically based priority setting and resource planning for national AIDS programmes (35).

UNAIDS is also an important source of normative policy and programme guidance, developed and made available through the UNAIDS secretariat and Cosponsors, at global and national level.

### *(h) US Government*

The US government's support to scale up efforts to fight AIDS, tuberculosis and malaria is provided through a range of mechanisms for disease-specific programming, such as programme support from USAID, the Presidential Emergency Plan For AIDS Relief, and the President's Malaria Initiative (9; 36; 37) (each of which prioritises support to a number of focus countries); and direct technical financial contributions to global health initiatives such as the Global Fund. Health systems strengthening is prioritised both through disease-specific initiatives and through direct programmes including support to health information and commodity management systems. At the same time the US government initiatives

promote the use of non-governmental organisations in responding to the three diseases, as a complement to public health systems.

One of the US government's key initiatives to tackle specific barriers to effective scale up is the recent creation of a programme to provide technical support to Global Fund grants. This programme, in its initial phase, aims to help fill this "underfunded mandate", by providing up to US$35 million to fund technical support aimed at resolving some of the principal organisational and system-related bottlenecks in Global Fund grant implementation.

### *(i) WORLD HEALTH ORGANIZATION (WHO)*

Much of the WHO's contribution to scaling up responses to AIDS, tuberculosis and malaria is reflected in the key roles it plays in global partnerships such as Stop TB, RBM, UNAIDS, and IHP+. The WHO works on many of the key challenges outlined above, including global and national advocacy to increase commitment to efforts against AIDS, tuberculosis and malaria, the provision of normative guidance for programmes, support to initiatives to improve the reliability of drug and commodity supplies, and country level technical support.

WHO is playing a particular leadership role in addressing issues related to health systems strengthening in general, and human resources for health in particular, and is convening the Alliance for Health Systems and Policy Research (38) and the Global Health Workforce Alliance (39), which aim to further develop appropriate strategies and problem solving, as well as raising awareness of the critical challenges and advocating for increased and sustained funding.

### *(j) WORLD BANK*

With the development of the Global Fund and of other global initiatives to fight the three diseases, the World Bank's role as a provider of financial support for diseases specific programmes is becoming less prominent. Nonetheless, the Bank plans to continue providing considerable levels of financial support to programme implementation (8; 17; 40). The Bank's disease-focussed strategies pay attention to many of the key challenges, particularly in relation to building national commitments to fight the three diseases, enhancing strategic planning at country level (including promoting multisectoral approaches and integration of disease control efforts into broader development priorities), and strengthening of health systems as a core component of disease programmes. The disease specific strategies also reflect a commitment to help ensure that what the Bank has learned in programme implementation informs other major initiatives.

It is therefore expected that one of the key contributions of the World Bank to scale-up of the fight against AIDS, tuberculosis and malaria will be in the area of health systems strengthening. The Bank is developing an enhanced role in strengthening health systems that will provide a better basis on which disease-specific initiatives of other actors can achieve results. The Health, Nutrition and Population strategy outlines ways in which health systems strengthening work supported by the Bank will support disease-focussed programming, as well as ensuring better coordination of support and stronger governance at national level (6).

## D: CONCLUSIONS

This overview shows that the key actors involved in providing financial and technical support to efforts to "scale up to meet the need" are in agreement over the nature and implications of the main barriers to their efforts. It also shows that there are considerable efforts and commitments to tackle these barriers. Although some agencies are focussing their efforts on specific barriers, according to their "comparative advantage", others are actively taking on several issues.

What is less clear is the extent to which these efforts are coordinated at global and national levels in a way that ensures that each receives the correct level of priority. It is also not possible, from this review, to identify the extent to which general statements of commitment, as they appear in the various strategic frameworks of each agency, might mask underlying differences of philosophy and approach. As an example, broad agreement on the necessity of strengthening health systems in order to sustain the impact of disease programmes does not necessarily reflect broad agreement on the best way to go about strengthening health systems. Similarly, there is a high level of consensus on the potential contribution of civil society and private sector actors in scaling up the response to AIDS, tuberculosis and malaria, but views on the precise role these sectors can play in fighting each disease, and strategies for involving them, differ considerably. Moreover, it is likely that broad principles will have quite different applications in each country, given the varied nature of epidemics, of needs, and of the capacity to respond. With this in mind, the increasing emphasis on strengthening commitments, systems, partnerships and planning at country level is a welcome development.

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